Health Home Quality Improvement Workgroup - 6/08/2022

Participants

Pamela Lester IME	**Heidi Weaver IME**	LeAnn Moskowitz IME
Tami Lichtenberg IME	David Klinkenborg AGP	**Sara Hackbart AGP**
Tori Reicherts ITC	**Bill Ocker ITC**	**Flora Schmidt IBHA**
Susan Seehase IACP	**Kristi Oliver Children's Coalition**	Paula Motsinger IME
Stacy Nelson Waubonsie	**Amy May Waubonsie**	**Geri Derner YSS**
Jen Cross Orchard Place	**Kim Keleher Plains**	**Andrea Lietz Plains**
Melissa Ahrens CSA	**Christina Smith CSA**	**Faith Houseman Hillcrest**
Ashley Deason Tanager	**Stephanie Millard First Resources**	**Kristine Karminski Abbe**
Shawna Kalous Plains	**Rich Whitaker Vera French**	**Jamie Nowlin Vera French**
Crystal Hall Tanager	Brooke Johnson Abbe	Mike Hines Tanager
Karen Hyatt DHS	Ericka Carpenter Vera French	Kelsey Poulsen Tanager
Krystal Arleaux Orchard Place	Kellee McCrory U of I	

Notes

Last meeting Notes:

- No questions/concerns from group.

Reviewed topics discussed during last Meeting

- Discussed the 99490 and the informational codes in the Director's meeting. There was ambiguity on changing this. A survey will be sent out to all of the directors as a follow-up to the meeting.
- Discussed potential change to a high, medium, low tiering and either using all of the same tool to determine tier or a crosswalk to ensure all tools will get to the same result.
- No questions from the group.

Draft Workgroup Report:

Page 2: Health Home Provider Standards

- Further research on “Complete status reports to document member's housing, legal, employment status, education, custody, etc.” so the group can discuss formal recommendations.
- After reviewing with LeAnn, this needs to remain. We can add this to the process parking lot.

Page 3: Health Home Provider Standards

- Made the following updates as shown below.
    - *SPA Page 19, the group recommends making Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State two bullets.*
    - *Participate in ongoing process improvement on clinical indicators and ~~overall cost effectiveness~~ specified by and reported ~~by~~ to the State and Lead Entities.*
    - *Participate in ongoing process improvement on ~~clinical indicators~~ overall cost effectiveness within the Health Home. Notes April 13, 2022 Page 5*
- No questions/responses from the group
- More discussion around Health Information Technology to come

Page 4: Member Qualifications

- Kristine Karminski - Regarding restoring the list of diagnoses from the 2016 SPA, what if the member's diagnosis is not listed? Would we then look at the functional impairment?
    - Pam - should we make this more clear?
        - Kristine Karminski - could be another qualifying diagnosis?
            - Pam will add in updated language and include all of the qualifying diagnoses from the 2016 SPA and SED for children and review with the group at the next meeting.
            - Group agreed
- Kristine Karminski - for the provider type, is primary care an option if they have the psych background?
- Geri Derner- have a good # of Peds managing and prescribing meds. Is it just within their practice? Or is it built into their credentials?
- Kristine Karminski- in the SPA, maybe add "authorized under their licensure/degree"
- Geri Derner- agree, if PCP isn't going to prescribing and monitoring the member's psych meds then it is not in their scope of practice. If the medical practice feels they have the credentials to do this, that should be acceptable. Need to reword to cover those practitioners who have it in their scope of practice.
- Pam - Sounds like the group is saying they would like to update to include "authorized under their licensure to manage the diagnosis and treat".
- Geri Derner- will ARNP be accepted? We have members being managed by an ARNPs and PAs.

Page 5: Member Qualifications

- *Allow the functional impairment tool to be completed by the IHH*
    - Pam - Anything to add to the bullet?

- Kristine Karminski - Would the functional impairment in the definition be changing?
    - Pam - the functional impairment definition comes from code so that won't change.
- Kristine Karminski - can there be checkboxes? Or does it need to be more narrative? Prefer to not have another tool. Or does it need to be more robust?
    - Pam - Checkboxes alone will not be adequate, still need the narrative of how and what that is. Changes need to ensure there is clarity in the functional impairment.
    - Kristine Karminski - We listed the auto-qualifying diagnosis or listed the diagnosis and a paragraph where they wrote a statement that outlined the functional impairment.
    - Andrea Lietz - similar to the process Kristine outlined - would list diagnosis. If not auto qualifying would support with functional impairment in the enrollment form. Typically completed by the care coordinator or nurse.
        - Pam - was that information based off on the assessment or clinical info from the PCP, therapist, etc?
            - Andrea Lietz - from all
                - Included in their documentation, based on assessment, MHP and PCP

Page 5: Team Qualifications

- Nurse Care Manager
    - *Add LPN as an optional additional role to support the RN, BSN.*
        - Pam - the outcome from last meeting was to take this back to your agency to discuss. Any feedback, information to share from your discussions?
            - Shawna Kalous - did talk about this with her team, don't think there is a need for an LPN. Haven't struggled with hiring RNs.
            - Rich Whitaker - don't see that an additional role would be helpful. The LPN with extensive experience can be an alternative to an RN not an additional role.
                - Pam - nursing board defines the scope. RN would need to sign off what is done by the LPN
                - Rich Whitaker - would an RN be a lead nurse and there be 2 or 3 LPNs?
                    - Pam - could you support an LPN role?
            - Kristine Karminski - the IHH are varying in size, some IHHs can, some not. Some tasks are not "sign-offable". Maybe helpful for some IHHs.
            - Melissa Ahrens - no harm in adding as long as it is optional.
            - Geri Derner agrees

- Pam - so do you feel that is an option that can be added? Rich Whitaker- feel comfortable with adding as an optional Kim Keleher - feels comfortable as long as it is optional Christina agrees

Member and Team Qualifications Brainstorming

Health Home Services

Using the Federal guidance document how would you define each Health Home Service, what activities would fall under that service, who would do what and how would you use HIT to complete the Health Home Service?

- *Must ensure activities are whole person and person-centered, team-based approach*
- *Coordinate across all elements of the health care system and provide linkages to medical and social resources in the community.*
- *Describe how HIT will be used to link each service in a comprehensive approach across the continuum of care.*

Comprehensive Care Management

Definition: Comprehensive Care Management means the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan which addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

- What would you add or leave the same?
  - Kristine Karminski - where is the definition from? CMS or Iowa
  - Pam - Iowa
  - No response from group- no changes

Activities under this Health Home Service

- *Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.*
- *Completing a comprehensive needs assessment.*
  - *Current and historical information provided by the enrollee, as well as information received from available health care records, input received through consultation with other health care providers and the enrollee's support member, and assessments performed by telemedicine or other information technology medium as appropriate.*
  - *physical examination, behavioral assessment, medication reconciliation, functional limitations, screenings as deemed appropriate, assessment of clinical and social support needs, and any "at risk" concerns. Information received from the comprehensive assessment then serves as the basis for the person-centered care plan.*
  - *Conducted at least every 12 months (or more frequently as needed), when the individual's needs or circumstances change significantly, or at the request of the enrollee or the enrollee's support member.*

Pam- What are the activities that need to be under this service?

- Kristine Karminski - feel like the activities that are listed align well with the SPA. Just to note, in Federal guidance - Doesn't specify who is taking the lead on the assessment like it does in the SPA.
  - Pam- really needs to be a team-based approach. Everyone is involved in the assessment and planning. The nurse has to oversee that.
  - Kristine Karminski - shall we adjust in the SPA?
    - Pam - in the Spa - make more clear the team completes the assessment.
    - Kristine Karminski - seems like it is nurse heavy on completing the assessment.
      - Pam - our activities, outreach and engagement comes from the assessment and completing the plan. Need to discuss the who.
      - Geri Derner - struggle with how much responsibility is placed on the nurse.
- Pam - who does what activities? Need to stick to what the requirement is and what the code says what can and cannot do.
- Geri Derner - struggled with code
  - Pam - code changes are separate from this discussion.
  - Kristine Karminski - would be good to know those references in code, to have a visual. Some could be carved out, e.g., medication reconciliation.
- Pam- what pieces are your nurses doing?
- Kristine Karminski - records review (CC, BPs, Med list reconciliation)
  - Andrea Lietz - echo what Kristine says. They are getting the records, medication reconciling, etc. The Care Coordinator is doing the bulk of the rest of the assessment
    - Jamie Nowlin - we run the same way
- Pam - What does your Peer Support/Family Peer Support do?
  - Kristine Karminski - they may contribute to the assessment, for instance if they have knowledge of the member. May help Care Coordinator to connect with the member, may sit in with the assessment, provide input, etc.
  - Shawna Kalous - they provide input, sit in on the assessment
  - Kristine Karminski - in the service definition - tease out the bullet points - can it be more broadened (completed by HH team) otherwise or the roles of the team? It has the Care Coordinator can assist, wondering if the Care Coordinator and Nurse Care Manager can be doing the delivering of the service.
    - Pam- do you have all the roles sign the assessment? I am hearing that for the Peer Support it is a hit or miss.
      - Melissa Ahrens- if they are involved
      - Geri Derner- having the Family Peer Support involved is specific to the situation.

        - Having them a part of the assessment can help with engagement and support the member.
    - Pam - Doesn't sound like there are activities to add, it is more about the who. What can be proposed to change around the "who" to better clarify?
        - Richard Whitaker - we have a couple of Peer Supports who are very education and qualified, could they have a role in the assessment process?
    - Pam - based off today's conversation - the Peer Support does have a role. What needs to be clarified in the SPA?
        - Kristine Karminski- broad in SPA for the nurse. Not sure if the rule section we need to break down their individual roles with the assessment.
            - Jamie Nowlin - "as is" it works. If we get more specific it will limit flexibility.
                - Geri- agrees
    - Pam - group agrees - the SPA language for who can do the activities for the assessment stays the same - no changes

Developing a comprehensive person-centered care plan

- Pam - What are your thoughts currently on the SPA on who can do what activities for the person-centered care plan?
    - No response from group - no changes

Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.

- Pam - any updates or changes you would recommend for the SPA?
    - Kristine Karminski - don't think so, for outreach activities can do what is in their scope of practice and the Peer Support can assist as needed.
    - Melissa Ahrens - agrees
- Kristine Karminski - one section of the SPA language it talks about monthly reporting…. standard of care guidelines….. seems really wordy.
    - Pam- what does the group think? Shall we discuss at next meeting?
        - Shawna Kalous- yes, agree to discuss at next meeting
        - Jennifer Cross – agrees
        - Pam will add to next meeting discussion

What does the use of HIT look like under comprehensive care management?

- Rich Whitaker - feels like the MCO does not provide too much pop health information. Unable to do comprehensive searches of the data. Feels like it is constrained.
    - Pam - the MCOs have claims data, do not have the SDOH and all of the info in your EHR on a population health level.
- What are the system requirements? Claims data can be old data. How do you complete these activities? How do you use HIT to complete these activities or how should you be using HIT?
    - Richard Whitaker - claims data can be beneficial and actionable. Haven't been given access to the claims data like they would like

to. Don't want to toss out claims data all together, need to see trends.
    - Pam- claims data is helpful but doesn't give you a whole person look. You are entering the plan and assessment as structured data. Need to articulate what this needs to be.
        - Sara Hackbart - the Gap in care reports, not everyone looks at those, if you haven't, I encourage you to do so.
- Kim Keleher - what we are trying to achieve with the HIE - an easy place to store and retrieve information from various providers. Find it difficult to connect with other providers. This is a barrier.
    - Pam - current Iowa HIE does not store information, it has different "switches".
        - Kim Keleher - we do pay for Patient Ping so we can get real time claims data. Very expensive. Understand that the MCOs use this already, so is it necessary for the HHs to cover this expense as well? Not all providers are a part of Patient Ping.
            - Pam - MCOs do provide reports from Patient Ping. The HIE has more "switches" than Patient Ping. Some providers use their own HISP, that is an issue for sharing data.
                - Christina Smith - barrier is integrating the data, have access but hard to get it all usable. It's an administrative burden, we don't have a person looking at each person individually in the portal, very time consuming. We can look at a report but how can we get that information into the EHR. Is there a way to get the data quicker?
                - Richard Whitaker - we are using Patient Ping as well. Get information real time.
                - Tori Reicherts - feel this is another whole day discussion. The MCOs are always looking at data and gathering data. This is a two way street. The Gaps in Care report - do you know how to look at this information?
                    - Kim Keleher - agree to have this as a separate discussion.
                        - Pam - will add this as a topic of discussion outside of this meeting.

- Kim Keleher - this is more about improving processes since everyone has a different EHR with different capabilities. This needs to be pulled out as a separate focus.
- Pam - not additions under HIT for this Health Home service but future work to do together.
    - Christina Smith - lets ensure that the directors bring their data folks as part of the discussions as well
- No other suggestions for changes from the group on Comprehensive Care Management

Care Coordination

Pam - In 2016 there was a legislative mandate for the state to review the Health Home program. As a result of the mandate chart reviews were conducted. In looking at the outcomes of those reviews, Care Coordination was identified the most. The struggle is identifying the correct Health Home service. Does that service fall under a different service or does it truly fall under Care Coordination?

Definition - Care Coordination means facilitating access to, and the monitoring of, services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes and to promote wellness.

- Is there anything that needs to be changed?
    - Jamie Nowlin - maybe stating SDOH could be part of it (rounded up to wellness)
    - Melissa Ahrens- not sure anything else should be part of the definition. Agree with Pam with identifying the correct Health Home service.
        - Pam – hearing from the group – asking the chart review feedback process include guidance on what Health Home service should have been selected
            - Group agrees - no changes

Activities under this Health Home Service

- *Facilitation of the interdisciplinary teams to perform a regular review of person-centered care plans and monitoring service delivery and progress toward goals. This is accomplished through face-to-face and collateral contacts with the Health Homes enrollee, family, informal and formal caregivers, and with primary and specialty care providers.*
- *It also includes facilitation and sharing of centralized information to coordinate integrated care by multiple providers through use of electronic health records (EHRs) that can be shared among all providers.*
- *Implementing the person-centered care plan.*
- *Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.*
- *Supporting the enrollee's adherence to prescribed treatment regimens and wellness activities.*

    - *Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting. (Transition of Care)*
    - *Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.*
    - *Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress.*
- Any recommendations for changes for any of the activities listed?
    - No changes recommended by the group
- HIT: Any recommendations for changes under Care Coordination? How is HIT used to complete these activities? Are they the same as Comprehensive Care Management?
    - Kim Keleher- Yes, would think so. HIT is a work in progress across the state.
    - Richard Whitaker - feels like the haves and the have nots. Would help if there was more a state solution.

Next Meeting:

- Health Home Services - will continue with Care Coordination
- Follow up on Comprehensive Care Management. Statement below is wordy and want to provide feedback on how to improve.
    - At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines (Page 28 under Service Definition)
- Share survey results regarding PMPM code change, HH Service reporting, and impairment documentation. (Deadline to respond is June 17th)